



## Patient Financial Policy

Thank you for choosing Temecula Valley Cardiology as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

### Please initial each line below:

\_\_\_\_\_ **Co-pays/Co-Insurance/Deductibles** -The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, deductibles and past due balances are due prior to treatment.

\_\_\_\_\_ **Insurance Claim**- As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to those charges above the usual and customary allowance. If we are out of network, and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately. Interest at the rate of 12% may be charged to your account if payment is not received by the due date

\_\_\_\_\_ **Self-pay Accounts**- Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

**Patient Name:**

**Date of Birth:**

\_\_\_\_\_ **Assignment of Benefits**- I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare,

private insurance and any other health/medical plan to issue payment check(s) directly to Temecula Valley Cardiology. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_ **Workers' Compensation** -In the case of a workers' compensation injury, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

\_\_\_\_\_ **Cancellation of Appointments**-Temecula Valley Cardiology requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of \$25.00 for office visits, \$50.00 for stress treadmills and echocardiograms, and \$150.00 for Nuclear Stress Test.

\_\_\_\_\_ **Returned Checks**- The charge for a returned check is \$25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

\_\_\_\_\_ **Medical Record Copies**- Patients requesting copies of medical records will be charged a fee of \$25.00. There is also a charge to complete third party forms.

\_\_\_\_\_ **Outstanding Balance Policy**- A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance is outstanding and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the Practice. In the event an account is turned over to collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

*This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.*



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Patient Name DOB Date

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Patient/Responsible Party Signature: Date

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TVC Staff Signature Date

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